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Comprehensive school health education is a planned, sequential curriculum of experiences presented by qualified professionals to promote the development of health

knowledge, health-related skills, and positive attitudes toward health and well-being for students in preschool through grade 12. Comprehensive school health education is one facet of the comprehensive school health program, which includes school health services and a healthful school environment, as well as health instruction. This Digest will focus on the instructional component of the comprehensive school health program.

Schools are unique among U.S. institutions in their access to children. They are a logical place to provide health information, not only to improve health in the childhood years but to prevent illness, disability, and health care costs later in life. Health education literally empowers students to avoid health risks.

Although school health education is now recognized as a national priority (U.S. Public Health Service, 1990), most American students have little or no health education (Pigg, 1989; Corry, 1992). Education codes establish a mandate for health education in 43 states; 36 of these states have a legal requirement for health instruction (Lovato, Allensworth, & Chan, 1989). Nevertheless, how the states define health instruction varies considerably, as evidenced by the variation in state funding for health education (ranging from $500 to $2 million annually) (Lovato, et al., 1989). Some children receive health instruction in only one grade; others get a fragmented "crisis-driven" approach that focuses on one problem, such as drug abuse or HIV infection.

CONTENT OF THE COMPREHENSIVE SCHOOL HEALTH INSTRUCTIONAL PROGRAM

Health education can often be integrated into other curricular areas. For example, a mathematics unit may include an exercise on calculating exercise heart rates, or a social studies class could examine state laws on drinking and driving. However, health should be treated as a separate subject in junior and senior high school (Dunkle & Nash, 1991).

It is recommended that the following 10 areas be included in any comprehensive school health program, whether the program is integrated or a separate subject: community health, consumer health, environmental health, family life, mental and emotional health, nutrition, personal health, chronic and infectious disease prevention and control, safety and accident prevention, and substance use and abuse (Joint Committee on Health, 1990; Joint Committee of the Association, 1992). Once a comprehensive program is in place, topical issues such as HIV/AIDS and teenage pregnancy can be incorporated into the program as needed. Each community should also build its health curriculum to reflect local needs, interests, and cultural and ethnic diversity.

THE IMPORTANCE OF COMPREHENSIVE SCHOOL HEALTH EDUCATION

Student knowledge is significantly improved as a result of health instruction (Seffrin, 1990). More importantly, considerable evidence demonstrates that health attitudes, skills, and behaviors are also enhanced (Pigg, 1989). For example, students who have had comprehensive school health education are less likely to drink, smoke, take drugs, or ride with drivers who have been drinking than are students with little or no health instruction (Pigg, 1989). Health instruction significantly decreases teenage pregnancy rates (Cortines, 1990).

The most comprehensive evaluation of school health education was the School Health Education Evaluation (SHEE) study conducted in the early 1980s (Connell, Turner, & Mason, 1985). SHEE involved more than 30,000 fourth through seventh graders in over 1,000 classrooms from 20 states. Among its findings was the observation that at least 50 classroom hours of instruction were needed before students demonstrated significant changes in health attitudes and behaviors. It is generally recommended that students receive 50 classroom hours of instruction per year in health (English & Sancho, 1990).

TEACHER PREPARATION IN HEALTH EDUCATION

According to the Association for the Advancement of Health Education (AAHE) and the American School Health Association (ASHA), "Lack of teacher training has been identified through national surveys as one of the most significant barriers to the effective implementation of school health education, especially at the elementary level" (Joint Committee of the Association, 1992). At the secondary level, most states (39) require teachers to be certified in health education by the State Department of Education in order to teach it. Only one state has such a requirement at the elementary level, even though 19 states require that health education be taught sometime during grades 1 through 6 (Lovato et al., 1989).

AAHE recommends that all persons teaching health education at the secondary level or higher be certified in health education by the state. To better prepare the elementary teacher, AAHE and ASHA recommend that preservice education for elementary classroom teachers include at least one 3-credit course in personal health (which should include the 10 content areas of a comprehensive school health education program) and an additional 3-credit course in elementary health education.

A certification program for health educators independent of state requirements has been available since 1989 through the National Commission for Health Education Credentialing (NCHEC). Anyone having a bachelor's degree with a health education emphasis may take the NCHEC certification examination, which measures competencies in assessing, planning, implementing, and evaluating health education programs; coordinating provision of services; acting as a health resource person; and communicating health and health education needs, concerns, and resources (Summerfield, 1991). Those who successfully complete the examination receive the

certified health education specialist (CHES) credential. At present there is no coordination between the CHES credential and state certification of health educators.

SELECTION OF A HEALTH CURRICULUM

Whether a school is using an existing health curriculum or developing its own, English & Sancho (1990) recommend evaluating health curricula on: (a) goals and objectives of the curriculum, (b) content, (c) teaching strategies, (d) learning activities, (e) materials, (f) time devoted to curriculum implementation, (g) evaluation methods, (h) cultural equity, and (i) sex equity. Below are several curriculum guides which may be accessed through ERIC:

Alabama State Department of Education. (1988). Alabama course of study: Health education. Bulletin 1988, No. 25. Montgomery: Author. ED 327 516.

Alaska State Department of Education. (1986). Alaska elementary health model curriculum guide, second edition. Juneau: Author. ED 274 637.

Arizona State Department of Education. (1990). Arizona comprehensive health essential skills. Phoenix: Author. ED 328 557.

Delaware State Department of Public Instruction. (1990). Health education curriculum standards K-12, revised. Dover: Author. ED 332 998.

Iowa State Department of Public Instruction. (1986). A tool for assessing and designing comprehensive school health education in Iowa schools. Des Moines: Author. ED 273 592.

Massachusetts State Department of Education. (1990). Comprehensive health education and human services. Draft program standards. Quincy: Author. ED 334 155.

Michigan State Board of Education. (1988). Michigan essential goals and objectives for health education. Lansing: Author. ED 310 103.

Missouri State Department of Elementary and Secondary Education. (1989). Comprehensive health competencies and key skills for Missouri schools. K-3, 4-6, 7-9, and 10-12. Jefferson City: Author. ED 312 259.

Montana State Department of Public Instruction. (1986). Montana health education curriculum planning guide. Helena: Author. ED 326 513.

Myers, M. L., & Doyen, M. A. (Eds.) (1989). School health education in Colorado: 1988 Colorado school health education survey. Denver: Colorado State Department of Education. ED 326 515.

New York State Education Department. (1986). Health education syllabus, grades K-12.

Albany: Bureau of Curriculum Development. ED 272 460.

Oregon State Department of Education. (1989). Health services for the school-age child, 1989 and supplement. Salem: Author. ED 320 693.

Texas Education Agency. (1987). The status of health education. Curriculum requirements for students and teachers. Austin: Author. ED 281831.

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Dunkle, M. C., & Nash, M. A. (Eds.). (1991). Beyond the health room. Washington, DC: Council of Chief State School Officers.

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Joint Committee on Health Education Terminology. (1990). Report of the 1990 Joint Committee on Health Education terminology. Reston, VA: Association for the Advancement of Health Education.

Lovato, C. Y., Allensworth, D. D., & Chan, F. A. (1989). School health in America: An assessment of state policies to protect and improve the health of students, fifth edition. Kent, OH: American School Health Association. ED 326984 (not available from EDRS)

Pigg, R. M., Jr. (1989). The contribution of school health programs to the broader goals of public health: The American experience. Journal of School Health, 59(1), 25-30. EJ 404 492.

Seffrin, J. R. (1990). The comprehensive school health curriculum: Closing the gap between state-of-the-art and state-of-the-practice. Journal of School Health, 60(4), 151-156.

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